GEORGIA STATE HEALTH PLAN

COMPONENT PLAN

APPENDIX A

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Ambulatory Surgical Services
Technical Advisory Committee

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Department of Community Health

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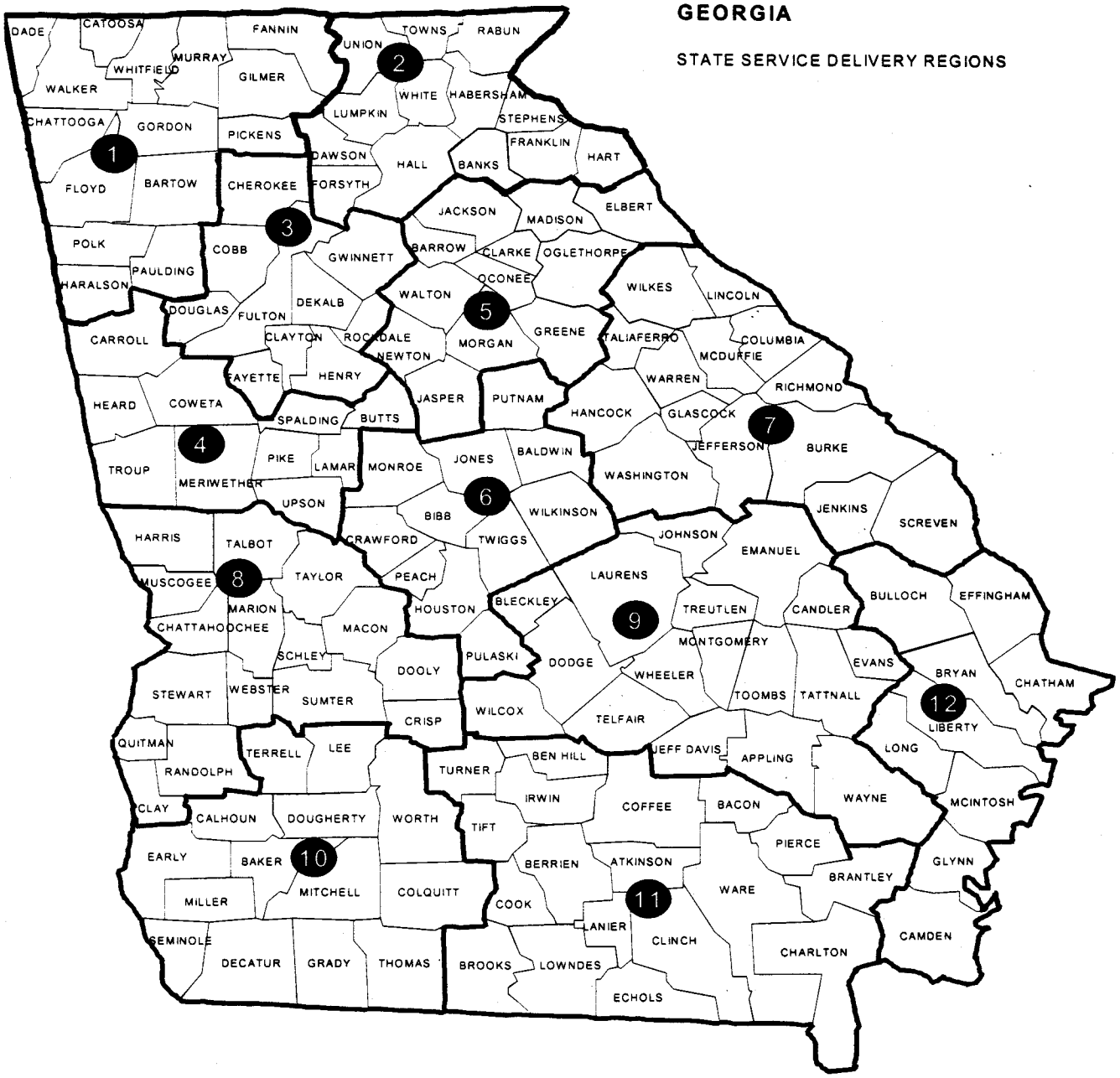
Office of Regulatory Services
Department of Human Resources

GEORGIA STATE HEALTH PLAN

COMPONENT PLAN

APPENDIX B

Map
Georgia State Service Delivery Regions (SSDR)



DRAFT
November 18, 2003

GEORGIA STATE HEALTH PLAN

COMPONENT PLAN

APPENDIX C

Inventory of Freestanding Ambulatory Surgery Centers in Georgia By State Service Delivery Regions

(as of September 17, 2003)

Inventory of Ambul[redacted]urgery Centers by State Service Delivery Region (SSDR) (As of 9/19/2003)					
[redacted]					
	County	**Facility Name**	**Existing Operating Rooms**	**Pending Operating Rooms**	**Total Operating Rooms**
	Catoosa	Hutcheson Medical Center Ambulatory Surgery Center		2	2
	Floyd	Surgery Center Of Rome	3		3
	Whitfield	Hamilton Ambulatory Surgery Center	4		4
		Total	**7**	**2**	**9**
[redacted]					
	County	**Facility Name**	**Existing Operating Rooms**	**Pending Operating Rooms**	**Total Operating Rooms**
	Forsyth	Northwoods Surgery Center	3		3
	Hall	Healthsouth Gainesville Surgery Center	3		3
		Total	**6**		**6**
[redacted]					
	County	**Facility Name**	**Existing Operating Rooms**	**Pending Operating Rooms**	**Total Operating Rooms**
	Cherokee	Advanced Surgery Center Of Georgia	3		3
	Clayton	Surgery Center at Mt. Zion	3		3
	Cobb	East-West Surgery Center	3		3
	Cobb	Marietta Surgical Center	7		7
	DeKalb	DeKalb Medical Ambulatory Surgery Center		3	3
	DeKalb	Dunwoody Outpatient Surgicenter (DOS)	3		3
	DeKalb	Emory Clinic Ambulatory Surgery Center	6		6
	DeKalb	Emory Orthopaedic Outpatient Surgery Center		2	2
	DeKalb	Emory Spine Physiatry Outpatient Surgery Center		2	2
	DeKalb	Northlake Surgical Center	2		2
	DeKalb	Northside Women's Clinic	3		3
	Fulton	Atlanta Center for Reconstructive Foot and Ankle Surgery	4		4
	Fulton	Atlanta EyeSurgery-NovaMed Eyecare Services	2		2
	Fulton	Atlanta Outpatient Peachtree-Dunwoody Center	6		6
	Fulton	Atlanta Outpatient Surgery Center	4		4
	Fulton	Atlanta Surgicenter	2		2
	Fulton	Atlanta Women's Medical Center	2		2
	Fulton	Buckhead Surgery Center	4		4
	Fulton	Center For Reconstructive Surgery	2		2
	Fulton	Children's Healthcare of Atlanta Surgery Center (at Meridian Mark Plaza), LLC	6		6
	Fulton	Feminist Women's Health Center	2		2
	Fulton	Healthsouth Center Of Atlanta	2		2
	Fulton	North Atlanta Endoscopy Center	3		3
	Gwinnett	Healthsouth Surgery Center Of Gwinnett	2		2
		Total	**71**	**7**	**78**

	County	Facility Name	Existing Operating Rooms	Pending Operating Rooms	Total Operating Rooms
	Troup	Southern Surgery Center	3		3
		Total	3		3

	County	Facility Name	Existing Operating Rooms	Pending Operating Rooms	Total Operating Rooms
	Bibb	Coliseum Same Day Surgery Center	3		3
	Bibb	Medical Eye Associates	2		2
	Bibb	Surgical Centers of Georgia		2	2
		Total	5	2	7

	County	Facility Name	Existing Operating Rooms	Pending Operating Rooms	Total Operating Rooms
	Columbia	Doctor's Hospital Surgery Center	4		4
	Richmond	Augusta Surgical Center	4		4
	Richmond	Planned Parenthood Reproductive Health Services, Inc.	2		2
		Total	10		10

	County	Facility Name	Existing Operating Rooms	Pending Operating Rooms	Total Operating Rooms
	Muscogee	Columbus Women's Health Organization, Inc.	2		2
	Muscogee	Endoscopy Center of Columbus, Inc.	2		2
	Muscogee	Novamed Eye Services, Surgery & Laser Center of Columbus	3		3
	Muscogee	The Surgery Center, LLC	4		4
		Total	11		11

	County	Facility Name	Existing Operating Rooms	Pending Operating Rooms	Total Operating Rooms
	Tift	Affinity Outpatient Service	2		2
		Total	2		2

	County	Facility Name	Existing Operating Rooms	Pending Operating Rooms	Total Operating Rooms
	Chatham	Savannah Medical Clinic	1		1
	Chatham	Savannah Outpatient Foot Surgery Center	2		2
	Chatham	Schulze Surgery Center, Inc.	2		2
	Glynn	Brunswick Endoscopy Center	2		2
	Glynn	Premier Surgery Center	2		2
		Total	9		9

** SOURCE: Georgia Department of Community Health/Division of Health Planning (9/2003)

** Report Criteria: ([facility type] in('Amb Surgery Center') AND [status] in('Operational', 'Not Yet Operational'))

GEORGIA STATE HEALTH PLAN
COMPONENT PLAN

APPENDIX D

Rules
Ambulatory Surgical Services

PROPOSED RULES
OF THE
GEORGIA DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF HEALTH PLANNING
CHAPTER 272-2
CERTIFICATE OF NEED

272-2-.09 Standards and Criteria. Amended.

(1) AMBULATORY SURGERY SERVICES.

(a) Applicability.

This rule applies only to those entities required to obtain a Certificate of Need (CON) and shall not apply to those entities otherwise exempt by rule or statute from obtaining a CON, including but not limited to facilities exempt under O.C.G.A. § 31-6-2(14)(G)(iii). For Certificate of Need purposes, an ambulatory surgery service is considered a new institutional health service if it is to be offered in a free-standing ambulatory surgery facility (ASF).

1. If the ambulatory surgery service is or will be provided as "part of a hospital", the hospital's provision of such service is not subject to CON review under this rule. For purposes of this rule, the following are always considered to be "part of a hospital":
   c. if the service is located within a hospital; or,
   d. if the service is located in a separate building on the hospital's main campus or on separate premises and the service is integrated with other hospital services and systems, and the services are billed through the hospital's Medicare or Medicaid provider number and/or license number issued by the Department of Human Resources.

   The Department of Community Health also will make a determination of reviewability on a case-by-case basis in other situations involving hospitals.

2. The legal entity that develops any ambulatory surgery facility subject to this rule shall be the applicant.

3. A single specialty ambulatory surgery service will be issued a single specialty CON. A new CON will be required for a single specialty ambulatory surgery service to become a multi-specialty service.

4. A party requesting designation as a physician-owned, single-specialty ambulatory surgery service that exceeds the capital expenditure threshold set forth in O.C.G.A. § 31-6-2(14)(G)(iii), and thus is not exempt from CON guidelines pursuant to this statutory provision, will be required to obtain a single specialty CON.

5. These rules do not apply to adult open-heart surgery, adult cardiac catheterization, pediatric cardiac catheterization, pediatric open-heart surgery, and obstetrical services because these services are covered under other CON rules.

6. If an ambulatory surgery facility seeks to expand the number of ambulatory surgery operating rooms and the capital expenditure exceeds the CON threshold, the expansion project will be reviewed under these rules.

7. A replacement ambulatory surgery facility shall not be required to meet the need and adverse impact provisions of this chapter; but shall be required to submit an application and comply with all other provisions of the chapter.

(b) Definitions.

1. "Ambulatory surgery" or "ASF" means surgical procedures that include but are not limited to those recognized by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association as reimbursable ambulatory surgery procedures. Ambulatory surgery is provided only to patients who are admitted to a facility which offers ambulatory surgery and which does not admit patients for treatment that normally requires stays that are overnight or exceed 24 hours and which does not provide accommodations for treatment of patients for periods of twenty-four hours or longer.

2. "Ambulatory surgery facility" means a public or private facility, not part of a hospital, which provides surgical treatment performed under general or regional anesthesia or monitored anesthesia care (MAC) in an operating room environment to patients not requiring hospitalization. In addition to operating rooms, an ambulatory surgery facility includes all components of pre and post-operative ambulatory surgery care. The term "ambulatory surgery facility" includes, but is not limited to entities such as an "ambulatory surgery center", an "ambulatory surgical treatment center", or by whatever name called meeting the within definition.

3. "Ambulatory surgery operating room" means an operating or procedure room located either in a hospital or in an ambulatory surgery facility that is equipped to perform ambulatory surgical procedures that are invasive and/or manipulative and are identified as surgical procedures in the most recent edition of the Current Procedural Terminology (CPT) coding of the American Medical Association, and is constructed to meet the specifications and standards of the Department of Human Resources. The term operating room also includes endoscopy and cystoscopy rooms and any rooms where scheduled procedures that are billed as surgical procedures are performed.

4. "Ambulatory surgery service" means the provision of ambulatory surgery including pre and post-operative care to patients not requiring hospitalization. An ambulatory surgery service may be provided within hospitals or ambulatory surgery facilities; provided, however, that an ambulatory surgery service provided as "part of a hospital" shall not be subject to these rules.

5. "Ambulatory surgery services patient" means a person who makes a single visit to an operating room during which one or more surgical procedures are performed.

6. "Expansion" or "Expanded Facility" means an existing ambulatory surgery facility that seeks to increase the number of operating and/or procedure rooms and the capital expenditures exceed the CON threshold.

7. "Health planning area" or "planning area" means the twelve (12) state service delivery regions as defined in O.C.G.A. § 50-4-7.

8. "Horizon year" means the last year of a five (5) year projection period for need determinations.

9. "Multi-specialty ambulatory surgery service" means an ambulatory surgery facility offering general surgery or surgery in two or more of the single specialties as defined in Rule 272-2-.09(b)(16).

10. "Not requiring hospitalization" means patients who do not require an inpatient admission to an acute care general hospital prior to receiving ambulatory surgery services, who normally would not require a surgical stay that is overnight or exceeds 24 hours, and who are not expected to require transfer to a hospital for continuing care following the surgical procedure.

11. "Official inventory" means the inventory of all facilities performing or authorized to perform ambulatory surgery services maintained by the Department based on responses to the most recent Annual Hospital Questionnaire (AHQ) Surgical Services Addendum and Freestanding Ambulatory Surgery Services Survey and/or the most recent appropriate surveys, questionnaires and other available official data relating to the provision of ambulatory surgery services, and any ambulatory surgery facilities that have been approved for a CON but are not currently operational or were not operational during the most recent annual survey filing cycle.

12. "Official state component plan" means the same as the "State Health Plan" as defined in Rule 272-1-.01.

13. "Operating room environment" means an environment, which meets the minimum physical plant, health and safety guidelines, and operating standards specified for ambulatory surgical treatment centers in the rules of the Department of Human Resources and the *Guidelines for Design and Construction of Hospital and Health Care Facilities*, American Institute of Architects Academy of Architecture for Health.

14. "Replacement" means new construction solely for the purpose of substituting another facility for an existing facility with the same or fewer number of operating rooms subject to 272-2-.09 (1)(c)(1). New construction may be considered a replacement only if the replacement site is located within a three (3) mile radius or less from the ambulatory surgery facility being replaced. Any new construction of an ambulatory surgery facility not meeting the definition for a replacement shall be required to obtain a CON as a new ASF.

15."Safety net hospital" means the same as "Safety net hospital" as defined in Rule 272-2-.09 (8).

16. "Single specialty ambulatory surgery service" means an ambulatory surgery facility meeting the definition in Rule 272-2-.09(b)(2) and offering surgery in one of the following specialties:

dentistry/oral and maxillofacial surgery,
dermatology,
gastroenterology,
obstetrics/gynecology,
ophthalmology,
orthopedics,
otolaryngology,
neurology,
pain management/anesthesiology,

physical medicine and rehabilitation,
plastic surgery,
podiatry,
pulmonary medicine, or
urology,

as evidenced by board eligibility or certification in the specialty.

17) "Teaching hospital" means the same as "Teaching hospital" as defined in Rule 272-2-.09 (8).

(C) STANDARDS.

1. Minimum Facility Size.

A proposed multi-specialty ambulatory surgery service shall have a minimum of three operating rooms. A proposed single specialty ambulatory surgery service shall have a minimum of two operating rooms.

2. Need Methodology.

The numerical need for a new or expanded ambulatory surgery facility shall be determined by a demographic formula which includes the number of ambulatory surgery services cases in a planning area. An ambulatory surgery patient represents one case. The following need calculation applies to each planning area.

(i) determine the current utilization rate for ambulatory surgery services for patients in each planning area by dividing the number of ambulatory surgery services patients served in ambulatory surgery operating rooms, hospital-based and free-standing, as reported in the most recent annual surveys, by the population for the planning area for the survey year;

(ii) determine the projected number of ambulatory surgery services patients in each planning area for the horizon year by multiplying the current utilization rate (step (i)) by the population for the planning area for the horizon year;

(iii) determine the number of operating rooms needed by dividing the number of projected ambulatory surgery services patients (step (ii)) by the optimal utilization per operating room. Capacity per operating room per year is 1,250 patients; optimal utilization is 1,000 patients per operating room per year. (This is based on 250 operating room days per year (50 weeks x 5 days/weeks) x 5 patients per room per day x 80 % utilization.);

(iv) determine the official inventory of ambulatory surgery operating rooms by adding:

(a) The pro-rata portion of hospital shared inpatient/ambulatory surgery operating rooms devoted to ambulatory surgery services. This portion is determined as follows:

$$\frac{\text{(number of ambulatory surgery patients x 90 min.)}}{\text{\{(ambulatory surgery patients x 90 min)+(inpatient surgery patients x 145 min.)\} x number of shared rooms}}$$

(b) Number of hospital dedicated ambulatory surgery operating rooms; and

(c) Number of ambulatory surgery operating rooms in ambulatory surgery facilities; and

(v) determine the projected net surplus or deficit for ambulatory surgery services by subtracting the total ambulatory surgery operating rooms needed (step (iii)) from the official inventory of ambulatory surgery services operating rooms in the planning area.

3. Exception to Need.

(a) The Department may allow an exception to the need standards referenced above, in order to remedy an atypical barrier to ambulatory surgery services based on cost, quality, financial access, or geographic accessibility. An applicant seeking such an exception shall have the burden of proving to the Department that the cost, quality, financial access, or geographic accessibility of current services, or some combination thereof, result in a barrier to services that should typically be available to citizens in the area and/or the communities under review. In approving an application through the exception process, the Department shall document the basis or bases for granting the exception and the barrier or barriers that the successful applicant would be expected to remedy.

(b) The types of atypical barriers outlined below are intended to be illustrative and not exclusive.

1. An atypical barrier to services based on cost may include the failure of one or more existing providers of ambulatory surgery services to provide services at reasonable cost, as evidenced by the charges and/or reimbursement for ambulatory surgical services providers in a given planning area being significantly higher (one or more standard deviations from the mean) than the charges and/or reimbursement for other similar providers in the state.

2. An atypical barrier to services based on quality may include the failure of one or more existing providers of ambulatory surgery services to provide services with outcomes generally in keeping with accepted clinical guidelines of the American College of Surgeons, peer review programs and comparable state rates for similar populations and/or procedures.

3. An atypical barrier to services based on quality and geographic accessibility also may include consideration that an applicant will provide clinical trials of ambulatory surgical procedures and/or single specialty services not available elsewhere in the planning area that are recognized on the registry of clinical trials maintained by the National Institutes of Health.

4. An atypical barrier to services based on financial access may include the repeated failure, as exhibited by a documented pattern over two or more years prior to the submission of the

application, of one or more existing providers of services within the community to provide services to indigent, charity and Medicaid patients.

5. An atypical barrier to services based on geographic accessibility may include a planning area or county within a planning area which does not have access to ambulatory surgical services, either through a hospital or a freestanding facility, within thirty (30) driving miles.

6. The Department also may consider an exception due to an atypical barrier to services based on geographic accessibility if the applicant is a designated, exempt physician-owned single specialty ambulatory surgery service seeking a CON as a single specialty ambulatory surgery service, and the single specialty service is the only service of its kind in the planning area, including hospital-based or freestanding ambulatory surgery services.

7. An atypical barrier to services based on geographic accessibility also may include consideration that an applicant for a single specialty ambulatory surgery service performs specialty procedures that require considerably more time than the need methodology contemplates (e.g., the complexity of the procedure(s) performed by the board certified specialty limits the number of patients that can be served a day on average) and, as such, the applicant contends that need methodology does not correctly reflect the service demand and need for the specialty. In seeking consideration for such an atypical barrier, an applicant must document to the Department the lack of availability of that discrete specialty within the planning area, either through a hospital or freestanding facility, and must sufficiently document the distinct nature of the services and procedures relative to other procedures measured by the need methodology.

4. Adverse Impact.

(a) Prior to approval of a new or expanded ambulatory surgery facility in any planning area, the aggregate utilization rate of all existing and approved ambulatory surgery services in that planning area shall equal or exceed 80 percent during the most recent survey year.

(b) An applicant for a new or expanded ambulatory surgery facility shall demonstrate in its application that the addition of the service will not be detrimental to safety net hospitals within the planning area. Such demonstration shall be made by providing an analysis in the application that compares current and projected changes in ambulatory surgery services market share and payer mix for the applicant and any safety net hospitals. A total decrease in ambulatory surgery procedures of 10% or more for any safety net hospital shall be considered detrimental.

5. Financial Accessibility.

An applicant for an ambulatory surgery facility shall foster an environment that assures access to individuals unable to pay, regardless of payment source or circumstances, by the following:

(vi) providing evidence of written administrative policies that prohibit the exclusion of services to any patient on the basis of age, race, sex, creed, religion, disability or the patient's ability to pay;

(vii) providing a written commitment that services for indigent and charity patients will be offered at a standard which meets or exceeds three percent (3%) of annual, adjusted gross revenues for the ambulatory surgery service;

(viii) providing a written commitment to participate in the Medicare, Medicaid and PeachCare programs;

(ix) providing a written commitment to participate in any other state health benefits insurance programs for which the ambulatory surgery service is eligible; and

(x) providing documentation of the past record of performance of the applicant, and any facility in Georgia owned or operated by the applicant's parent organization, of providing services to Medicare, Medicaid, PeachCare, and indigent and charity patients.

6. Favorable Consideration.

In considering applications joined for review, the Department may give favorable consideration to whichever of the applicants historically has provided the higher annual percentage of unreimbursed care to indigent and charity patients and the higher annual percentage of services to Medicare, Medicaid and Peach Care patients.

7. Quality of Care.

(a) An applicant shall provide evidence of a credentialing process, which provides that surgical procedures will be performed only by licensed physicians or by licensed oral and maxillofacial surgeons or by licensed podiatrists who are board certified/qualified by one of the boards, recognized by a specialty board recognized by the American Board of Medical Specialties (ABMS) or by the American Osteopathic Association (AOA), or by the American Board of Oral and Maxillofacial Surgery (ABOMS) or by the Council on Podiatric Medical Education and are board certified/qualified by such other board which is nationally recognized and has been deemed acceptable to and qualified as an equivalent such board as determined and certified at the sole discretion of the applicant's state licensing board. The applicant shall stipulate that the surgical procedures to be performed will be limited to those that are generally recognized as falling within the scope of training and practice of the surgeons providing the care.

(b) An applicant shall assure that the physicians or oral and maxillofacial surgeons performing surgical procedures will maintain privileges at an accredited or state licensed hospital in their geographic area for the procedures they perform in ambulatory surgery settings.

(c) An applicant shall assure that anesthesia will only be administered by an anesthesiologist, by a physician qualified to administer anesthesia, by an oral and maxillofacial surgeon, or by a certified registered nurse anesthetist; and that the anesthesia levels, patient selection and screening criteria, and pre-operative and post-operative guidelines of the American Society for Anesthesiologists (ASA) guidelines, or the guidelines of the American Association of Oral and Maxillofacial Surgeons (AAOMS) or

the *Scope and Standards for Nurse Anesthesia Practice* issued by the American Association of Nurse Anesthetists (AANA) and will be followed and so documented.

(d). An applicant shall assure that at least one physician, oral and maxillofacial surgeon or CRNA who is currently certified in advanced resuscitative techniques equivalent to Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS) or Pediatric Advanced Cardiac Life Support (PALS), as appropriate, must be on the premises until all surgical patients have been determined to be medically stable and such determination has been properly entered in each patients' anesthesia or recovery room record by the physician, oral and maxillofacial surgeon or CRNA in charge of administering the anesthesia. Thereafter, a licensed Registered Nurse who is currently certified in ACLS, ATLS or PALS must be on the premises until all patients are medically discharged by the facility. In addition, the applicant shall assure that other medical personnel with direct patient contact will, at a minimum, be certified in Basic Cardiac Life Support (BCLS).

(e) An applicant shall submit evidence that qualified personnel will be available to insure a quality service to meet licensure, certification and/or accreditation requirements.

(f) An applicant shall submit a policy and plan for reviewing outcomes of patient care and a plan for ongoing quality improvement activities, including a stated set of criteria for identifying those patients to be reviewed and a mechanism for evaluating the patient review process.

(g) An applicant shall submit written policies and procedures for utilization review consistent with state, federal, and accreditation standards. This review shall include review of the medical necessity for the service, appropriateness of the ambulatory surgical setting, quality of patient care, and rates of utilization.

(h) An applicant shall provide a written statement of its intent to comply with all appropriate licensure requirements and operational procedures required by the Georgia Department of Human Resources.

(i) An applicant that has previously operated and/or owned any type of health facilities in Georgia also shall provide sufficient documentation that any facilities currently or previously in business have no history of licensure adverse actions and no history of conditional level Medicare and/or Medicaid certification deficiencies in the past three (3) years and have no current outstanding licensure and Medicare and/or Medicaid certification deficiencies.

(j) An applicant for a new or replacement ambulatory surgery service shall provide a statement of intent to meet, within 12 months of obtaining state licensure, the appropriate accreditation requirements of the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care (AAAHC), the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAASF) and/or other appropriate accrediting agency.

(k) An applicant for an expanded ambulatory surgery service shall provide documentation that they fully meet the appropriate accreditation requirements of the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care (AAAHC), the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (ASF) and/or other appropriate accrediting agency.

8. Continuity of Care, Viability and Cost Containment.

(a) Each applicant shall have a hospital affiliation agreement and/or the medical director must have admitting privileges and other acceptable documented arrangements to insure the necessary backup for medical complications. The applicant must provide written evidence of a binding transfer agreement that documents the capability to transfer a patient immediately to a hospital with adequate emergency room services.

(b) An applicant shall submit written policies and procedures regarding discharge planning. These policies should include, where appropriate, designation of responsible personnel, participation by the patient, family, guardian or significant other, documentation of any follow-up services provided and evaluation of their effectiveness.

(c) An applicant shall demonstrate that the proposed services will be coordinated with the local existing health care system.

(d) An applicant shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the facility.

(e) An applicant shall demonstrate that proposed charges and/or reimbursement rates for services shall compare favorably with charges and/or reimbursement rates for other similar services in the planning area when adjusted for annual inflation. When determining the accuracy of an applicant's projected charges for ambulatory surgery services, the Department may compare the applicant's history of charges and/or reimbursement rates, if applicable, with other services in the planning area(s) previously served by the applicant or its parent company.

9. Data and Information Reporting Requirements.

An applicant for an ambulatory surgery facility shall document an agreement to provide all Department requested information and statistical data related to the operation and provision of ambulatory surgery and to report that data to the Department in the time frame and format requested by the Department. This information may include, but not be limited to, financial data, patient and procedure volume, utilization and charge data, and any changes in number of ambulatory surgery operating and procedure rooms that may occur as a result of service expansion.

Summary of Law Department Review
of
TAC-Proposed Revisions to Ambulatory Surgery Services Rule

As you are aware, the Department asked the Department of Law to review the TAC-proposed revisions to the ambulatory surgery services regulation. Staff at the Department of Law carefully reviewed the proposed revisions and provided feedback to the Department. The Department has summarized the Law Department's findings below.

1. **Exclusion of freestanding facilities remote from hospital campuses but owned by a hospital or billed under a hospital's provider number is in contravention of the CON Statute**

   The CON Statute precludes defining the term, "part of a hospital," to include freestanding facilities integrated with and billed under a hospital's provider number if such facilities are not on a hospital's campus. The CON statute, at OCGA § 31-6-2(1), defines an "ambulatory surgical service" as a facility, which is not part of a hospital. The phrase, "not part of a hospital" refers to geographic location, and not just to ownership. Comparatively, other provisions within the statute use terms such as "owned by," "operated by," and "utilized by" certain entities or individuals. *C.f.* OCGA § 31-6-2(14)(G)(iii)(exempting from CON review ASCs that are "owned, operated and utilized by private physicians.") Furthermore, the statute clearly maintains that Certificates of Need are location specific and places particular emphasis on location throughout.

   Action Needed: Freestanding facilities which are not located on a hospital's campus must be reviewed in the same manner as all other freestanding facilities. As the proposed revision provides to the contrary, it must be revised.

2. **Distinct criteria for replacement facilities is authorized as long as such distinctions have a rational basis**

   As long as a rational basis for distinguishing criteria for replacement and new facilities is identified, replacement facilities may be reviewed under separate and distinct review criteria. Since the revisions were proposed, the Department has developed and promulgated several generally applicable rules regarding replacement facilities.

   Action Needed: The component plan should be revised to identify a rational basis for distinct review criteria for replacement facilities. In addition, the proposed revisions must be revised to comport with the Department's current regulations regarding replacement facilities.

3. **Inclusion of rooms where surgical treatment is performed solely without anesthesia, with a level of anesthesia less than regional, or in an environment that does not meet the standards for operating rooms established by the Department of Human Resources is not authorized by Statute**

The CON statute, at OCGA § 31-6-2(1), defines an "ambulatory surgical service" as a facility, which provides surgical treatment performed under general or regional anesthesia in an operating room environment. The proposed revision's definition of operating room may include rooms in which surgical treatment is performed without anesthesia or under minor or local anesthetics, such as endoscopies.

Action Needed: The proposed revision must be revised to exclude rooms that are used solely for surgical procedures not requiring anesthesia or requiring anesthesia at a level below regional. If a room will be licensed by DHR as an operating room it should be counted in the inventory of operating rooms, if it will not be so licensed, it cannot be counted in the inventory.

4. **The term "expansion" needs clarification to define the exact instances in which an application would be reviewed under the ASC rules and the general considerations as opposed to solely the general considerations**

The proposed revision states that a project would be reviewed under the ASC rule only when operating rooms are added and the cost exceeds the threshold. The revision does not clarify what would occur when operating rooms are added below the threshold or what would happen when the threshold is exceeded but no operating rooms are added. It is currently the practice of the Department to apply the ASC-specific rules whenever ORs are added regardless of cost.

Action Needed: The proposed revision should be modified to clarify when an ASC expansion project would be reviewed under the ASC rule and when it would be reviewed solely under the general considerations.

5. **Exhaustive lists of surgical specialties must provide rational bases for excluding non-included specialties or, in the alternative, a non-exhaustive listing should be employed along with regulatory criteria for determining a single specialty**

The CON statute does not specifically define "single specialty." Therefore, it is within the Department's authority to define this term (except for the inclusion of general surgery). The proposed revision employs an exhaustive listing of specialties which qualify as a single specialty. When certain items are excluded from an exhaustive list, administrative law requires that a reasonable basis for distinction be articulated.

Action Needed: The component plan must document a reasonable basis for the exclusion of specialties from an exhaustive list, or in the alternative, a non-exhaustive list should be employed. If a non-exhaustive list is employed, then the rule should specify objective criteria by which the Department can judge the eligibility of a specialty not specifically listed, e.g. by reference to a medical certification board.

HEALTH STRATEGIES COUNCIL MEMBERS

(as of October 2005)

Member and Affiliation	Category of Representation
Daniel W. Rahn, M.D., *Council Chairman* President, Medical College of Georgia Augusta	Member at Large
William G. Baker, Jr., MD Executive Director, Atlanta Regional Health Forum, Inc. Atlanta	Health Care Needs of Low-Income Persons
The Honorable Glenda M. Battle, R.N., BSN Decatur County Commissioner Association County Commissioners of GA Bainbridge	County Governments
Mr. Harve R. Bauguess President, Bauguess Management Company, Inc. Atlanta	Health Care Providers- Nursing Homes
VACANT	Health Care Needs of Older Persons
Mr. Edward J. Bonn, CHE President/CEO, Southern Regional Health System Riverdale	Health Care Providers – Urban Hospitals
VACANT	Health Care Needs of Populations with Special Access Problems
Ms. Elizabeth P. Brock, *(Vice Chair)* President, Pallets Incorporated Atlanta	Health Care Needs of Small Business
Mr. Tary L. Brown CEO, Albany Area Primary Health Care, Inc. Albany	Health Care Providers – Primary Care Centers

Member and Affiliation	Category of Representation
Mr. W. Clay Campbell Executive Vice President, Archbold Medical Center Thomasville	Health Care Providers – Home Health Agencies
Nelson B. Conger, D.M.D. Dalton	Health Care Providers – Primary Care Dentist
Ms. Katie Foster Ellenwood	Health Care Needs of Organized Labor
Charlene M. Hanson, Ed.D., FNP Professor Emerita, Family Nurse Practitioner Georgia Southern University Statesboro	Health Care Providers – Nurse Practitioners
VACANT	Health Care Needs of Persons with Disabilities
Reverend Ike E. Mack Pastor, Unionville Baptist Church Warner Robins	Member at Large
Felix T. Maher, D.M.D Savannah	Health Care Providers- Primary Care Dentist
Julia L. Mikell, M.D. Neurologist, Neurological Institute of Savannah Savannah	Health Care Providers – Specialty Physician
Mr. Jim Peak CEO, Memorial Hospital & Manor Bainbridge	Health Care Needs of Populations with Special Access Problems
VACANT	Health Care Needs of Large Business

Member and Affiliation	Category of Representation
Mr. Raymer Sale, Jr. President, E2E Resources, Inc. Lawrenceville	Private Insurance Industry
Mrs. Toby D. Sidman Past President, Georgia Breast Cancer Coalition & Georgia Breast Cancer Coalition Fund Atlanta	Health Care Needs of Women
Ms. Cathy P. Slade Director, Georgia Medical Center Authority Augusta	Health Care Needs of Populations with Special Access Problems
Oscar S. Spivey, M.D. Professor and Chairman Emeritus of Pediatrics Mercer University School of Medicine Macon	Health Care Needs of Children
Ms. Tracy Michele Strickland Associate, Life Science Practice Group Spencer Stuart Atlanta	Member at Large
Mr. Kurt Stuenkel, FACHE President & CEO, Floyd Medical Center Rome	Health Care Providers – Rural Hospitals
Ms. Kay L. Wetherbee, R.N. Atlanta	Health Care Providers – Registered Nurse
David M. Williams, M.D. President/CEO, Southside Medical Center Atlanta	Health Care Providers- Primary Care Physician

The State Commission on the Efficacy of the Certificate of Need Program (Commission)

MATERIALS RECEIVED BY THE DEPARTMENT OF COMMUNITY HEALTH FOR DISTRIBUTION TO THE COMMISSION

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September 7, 2005

Dr. Daniel W. Rahn
Office of the President
Medical College of Georgia
1120 15th Street, AA-311
Augusta, GA 30912-7600

Dear Dr. Rahn:

Following my testimony to the Commission last month, it was called to my attention that I had made a mistake in responding to one question. My purpose with this letter is to clarify my response and, I hope, correct the record. The question, as I recall it, was whether for-profit hospitals could participate in the Indigent Care Trust Fund program. My answer was that to the best of my knowledge they could not.

While I would refer the Commission to the proper subject matter experts within the Department of Community Health for the most definitive answer to this question, I have since been informed that in fact for-profit hospitals can and do receive ICTF dollars based on the Medicaid burdens they shoulder. As I understand the current law and related regulations, the hospital funds used to attract the federal ICTF match can come only from not-for-profit hospitals, but the resulting federal match is shared among all qualifying hospitals, whether or not they were able to participate in the initial contribution.

As a point of further information, I was informed as I was preparing this letter that the state rules governing the distribution of ICTF funds may soon be revised by DCH. For that reason in particular, I would, again, refer the Commission to DCH for the most up-to-date and precise explanation of this issue.

I hope you find this helpful and would be pleased to answer any additional questions you might have.

Sincerely,

Kurt Stuenkel

Kurt Stuenkel
Chairman, Georgia Alliance of Community Hospitals
CEO, Floyd Medical Center

GHA An Association of Hospitals and Health Systems

1675 Terrell Mill Road • Marietta, Georgia 30067 • (770) 249-4500 • FAX (770) 955-5801 • www.gha.org

September 27, 2005

Daniel W. Rahn, M.D.
Chair
State Commission on the Efficacy of the Certificate of Need Program
c/o Georgia Department of Community Health
2 Peachtree Street, N.W.
Atlanta, GA 30303

Dear Dr. Rahn:

I am writing in response to your letter dated August 22, 2005, to Richard Dwozan, Chairman, Georgia Hospital Association (GHA) Board of Trustees. In the letter, you request that Chairman Dwozan provide the State Commission on the Efficacy of the Certificate of Need Program (Commission) with specific recommendations for improvement of the Certificate of Need Statute and the administrative processes associated with the Certificate of Need Program in Georgia.

As you know, GHA's member hospitals are united in their belief that a strong Certificate of Need Program is essential to assure Georgia's citizens enjoy broad access to high quality healthcare services at an affordable cost. GHA appreciated the opportunity to speak at the August 8, 2005, Commission meeting and is eager to assist the Commission. However, as we discussed in our recent telephone conversation, I believe it is premature to recommend specific changes to Georgia's Certificate of Need Program at this time.

As Chairman Dwozan noted in his remarks during the August 8th Commission meeting, Georgia's Certificate of Need Program significantly impacts numerous aspects of the healthcare delivery system. Chairman Dwozan provided the Commission with a list of suggested topics for upcoming meetings and encouraged the careful examination of these topics. I am attaching to this letter a copy of the list of topics previously submitted by Chairman Dwozan. GHA again urges the Commission to thoroughly explore the manner in which the Certificate of Need Program impacts each of these topics. GHA believes the information gleaned from this process will assist stakeholders, including GHA, in crafting meaningful recommendations to improve the Certificate of Need Program and will also aid the Commission as it considers the various proposals.

Thank you again for the opportunity to participate in this important initiative.

Sincerely,

Joseph A. Parker
President

Attachment

c: Governor Sonny Perdue; Commission Members; Glenn Richardson, Speaker, Georgia House of Representatives; Eric Johnson, Senate Pro Tempore

GHA An Association of Hospitals and Health Systems

1675 Terrell Mill Road • Marietta, Georgia 30067 • (770) 249-4500 • FAX (770) 955-5801 • www.gha.org

Suggested Topics
for
Upcoming Meetings
of the
Study Commission on the Efficacy of Georgia's
Certificate-of Need System

GHA encourages the Commission to carefully examine the following issues in considering the potential of revising the Certificate of Need Program:

- The history of the CON program and health policy goals it affects
- Impact on healthcare costs
- Impact on services volume and quality of care
- Financial access (indigent care; Medicaid; uninsured)
- Impact on safety net providers
- Impact on rural hospitals
- Impact on medical education
- Impact on trauma and emergency room services
- Physician self referral issues
- The perspectives of physicians, including hospital-based and primacy care physicians
- Assurance of hospital financial viability
- Long term care options and financing

We believe Georgia's CON Program significantly impacts each of these important issues. We urge the Commission to undertake a thorough discussion of each issue with input from the pertinent provider, payor and consumer communities, and with input from researchers who have studied the issues.

The Florida Senate

Interim Project Report 2006-138 *September 2005*

Committee on Health Care — Senator Durell Peaden, Jr., Chair

REVIEW THE MORATORIUM ON CERTIFICATES OF NEED FOR NURSING HOMES

SUMMARY

The 2001 Legislature imposed a moratorium on the approval of certificates of need (CONs) for additional community nursing home beds until July 1, 2006. The moratorium is found in s. 651.1185, F.S. The purpose of this moratorium is to slow the increase of nursing home placements and to encourage other forms of assistance to elderly individuals who need assistance. Limiting the number of nursing home beds limits the state's obligation to fund nursing home bed days for Medicaid recipients, thereby freeing state funds to pay for other types of noninstitutional community support for the elderly. If the 2006 Legislature does not extend the moratorium on CONs for nursing homes, the moratorium will expire on July 1, 2006.

This report recommends that s. 651.1185, F.S., should be moved to ch. 408, F.S., and amended to extend the moratorium on the approval of certificates of need for additional nursing home beds until July 1, 2011. In order to ensure access to needed nursing home services, an exception to the moratorium should be permitted to allow nursing homes with a 96 percent or greater occupancy rate to add 10 beds or 10 percent of the number of licensed beds if the home had no class I or class II deficiencies in the past 30 months and the occupancy rate in the planning subdistrict is 94 percent or greater. This exception is the same policy as the exemption to CON review under s. 408.036(3)(j), F.S., which is not currently available to nursing homes because of the moratorium. If the Legislature enacts this recommendation, the moratorium would stay in effect for five more years, and AHCA would have the authority to grant an exception to the moratorium for nursing homes that provide a good quality of care and that are operating at what is essentially full capacity.

BACKGROUND

Florida's Supply of Nursing Home Beds

Florida regulates the entry of nursing homes into the market and the expansion of those nursing homes through the certificate-of-need (CON) process. Since 1973, the CON process has limited Florida's nursing home bed supply in accordance with projected need. The number of community nursing home beds per 1,000 individuals age 65 and older during the past 10 years is shown in the chart below[1]:

Year	Population Age 65 and Older	Community Beds per 1,000 Population Age 65 and Older
1994	2,552,428	28.72
1995	2,587,344	29.15
1996	2,627,624	29.49
1997	2,667,509	29.98
1998	2,715,591	30.04
1999	2,778,024	29.78
2000	2,840,445	29.34
2001	2,899,099	28.54
2002	2,990,031	27.30
2003	3,057,275	26.47
2004	3,120,312	25.8

The Moratorium on Certificates of Need for Nursing Home Beds

The CON regulatory process under ch. 408, F.S., requires that before specified health care services and facilities may be offered to the public they must be approved by the Agency for Health Care Administration (AHCA). The establishment of a new nursing home or the addition of beds in a community nursing home is subject to CON review, which includes determination of the level of need that exists

[1] Source of data: Florida Agency for Health Care Administration. 2005.

for such services in a geographical area known as a planning district. These CON reviews are not currently being conducted for nursing homes and nursing home beds because of a legislatively-imposed moratorium on the approval of CONs for additional nursing home beds through June 30, 2006.[2] The 2001 Legislature's intent in enacting the moratorium was "to limit the increase in Medicaid nursing home expenditures in order to provide funds to invest in long-term care that is community-based and provides supportive services in a manner that is both more cost-effective and more in keeping with the wishes of the elderly residents of this state."[3] The moratorium does not apply to sheltered nursing home beds in a continuing care retirement community.

Two exceptions to the moratorium have been enacted since 2001; these exceptions are specified in s. 651.1185, F.S.:

- Under s. 651.1185(4), F.S., additional community nursing home beds may be added in a county that has no community nursing home beds and the lack of community nursing home beds occurs because all nursing home beds in the county that were licensed as of July 1, 2001, have subsequently closed.
- Under s. 651.1185(5), F.S., additional community nursing home beds can be added to nursing homes located in counties of up to 50,000 residents, in a number that may not exceed 10 total beds or 10 percent of the nursing home's current licensed capacity under certain conditions. Documentation accompanying the application to AHCA must:
  - Certify that the facility has not had any class I or class II deficiencies within the 30 months preceding the request for addition.
  - Certify that the prior 12-month average occupancy rate for the nursing home beds at the facility meets or exceeds 94 percent and the facility had not had any class I or class II deficiencies since its initial licensure.
  - For a facility that has been licensed for less than 24 months, certify that the prior 6-month average occupancy rate for the nursing home beds at the facility meets or exceeds 94 percent and that the facility has not had any class I or class II deficiencies since its initial licensure.

Such specificity limits the application of the exceptions to only a few nursing homes and thus, the exceptions have had minimal impact on the addition of community nursing home beds licensed under ch. 400, pt. II, F.S.

Requirements for CON Review for Nursing Home Beds

Section 408.036, F.S., specifies those health care projects that are subject to full comparative review in batching cycles by AHCA, those that can undergo an expedited review, and those that may be exempt from full comparative review upon request. The nursing home projects addressed in s. 408.036, F.S., are as follows:

Projects Subject to Full Comparative Review

- Adding beds in community nursing homes (*AHCA does not accept applications for additional community nursing home beds under this provision because of the moratorium.*)
- Constructing or establishing new health care facilities, which include skilled nursing facilities (*AHCA does not accept applications for new nursing homes under this provision because of the moratorium.*)

Projects Subject to Expedited Review

- Replacement of a nursing home within the same district
- Relocation of a portion of a nursing home's licensed beds to a facility in the same district

Exemptions from CON Review

- Addition of beds at a facility that is part of a retirement community which was established for 65 years prior to 1994 (*AHCA does not accept applications for additional nursing home beds under this provision because of the moratorium.*)
- State veterans nursing homes if 50 percent of the construction is federally funded
- Combining in one nursing home the beds or services authorized by two or more CONs in the same subdistrict
- Dividing into two or more nursing homes the beds or services licensed under one CON issued in the same planning subdistrict
- Adding 10 nursing home beds or 10 percent of the number of licensed beds (or for a Gold Seal facility 20 beds or 10 percent of the licensed beds) if:
  - The nursing home had no class I or class II deficiencies in the 30 months preceding the application
  - The occupancy rate for the previous 12 months was 96 percent or above

[2] S. 651.1185, F.S.
[3] S. 651.1185(2), FS.

- All beds previously authorized under this exemption have been operational for at least 12 months

(AHCA *does not accept applications for additional nursing home beds under this provision because of the moratorium.*)

- Replacement of a nursing home on the same site or within 3 miles of the site provided the number of beds does not increase
- Consolidation or combination of nursing homes or transfer of beds within the same subdistrict by providers that operate multiple homes in the subdistrict provided there is no increase in the total number of beds in the subdistrict

The expedited reviews and exemptions provided in s. 408.036, F.S., have given nursing homes the flexibility to relocate nursing home beds during the years the moratorium has been in effect.

Nursing Home Bed Need Methodology

Under s. 408.032(5), F.S., the state is divided into 11 planning districts, and under rule 59C-2.200, F.A.C., the planning districts are further divided into subdistricts. Rule 59C-1.036, F.A.C., establishes the CON review procedures for nursing facility beds. An application for nursing facility beds will not be approved in the absence, or insufficiency of, a numeric need, unless the absence or insufficiency of numeric need is outweighed by other information presented in a CON application showing special circumstances consistent with review criteria under s. 408.035, F.S. The planning horizon for applications is 3 years subsequent to the year the application is submitted. The estimate of projected population is the estimate for the planning horizon.

The need formula for nursing facility beds is based on the expected increase in the planning district's population age 65 to 74 and age 75 and over, with the age group 75 and over given 6 times more weight in projecting the population increase. The projected district bed need total is then allocated to its subdistricts consistent with the current subdistrict distribution of the total. The result for a given subdistrict is adjusted to reflect the current subdistrict occupancy of licensed beds and a desired standard of 94 percent occupancy. This subdistrict total of allocated beds is then reduced by the current number of nursing home beds in the subdistrict that are licensed or approved, resulting in the net need for additional nursing facility beds. If the current occupancy of licensed beds is less than 85 percent, the net need in the subdistrict is zero regardless of whether the formula otherwise would show a net need.[4]

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[4] The formula for determining the net need in a subdistrict for nursing home beds is as follows:
1. A = (POPA × BA) + (POPB × BB)
where:
A is the projected age-adjusted total number of nursing facility beds to be licensed under Chapter 400, F.S., at the planning horizon for the district in which the subdistrict is located.
POPA is the projected population age 65-74 years in the district.
POPB is the projected population age 75 years and older in the district.
BA is the estimated current bed rate for facilities licensed under Chapter 400, F.S., for the population age 65-74 years in the district.
BB is the estimated current bed rate for facilities licensed under Chapter 400, F.S., for the population age 75 years and over in the district.
2. BA = LB / (POPC + (6 × POPD))
where:
LB is the number of nursing facility beds licensed under Chapter 400, F.S., in the district as of January 1, for fixed bed need pools published between January 1 and June 30, or as of July 1 for fixed bed need pools published between July 1 and December 31.
POPC is the current population age 65-74 years in the district.
POPD is the current population age 75 years and over in the district.
3. BB = 6 × BA
4. SA = A × (LBD/LB) × (OR/.94)
where:
SA is the subdistrict allocation of community nursing facility beds to be licensed under Chapter 400, F.S., at the planning horizon.
LBD is the number of nursing facility beds licensed under Chapter 400, F.S., in the subdistrict as of January 1, for fixed bed need pools published between January 1 and June 30, or as of July 1 for fixed bed need pools published between July 1 and December 31.
OR is the average 6 month occupancy rate for nursing facility beds licensed in the subdistrict
.94 equals the desired average 6 month occupancy rate for licensed nursing home beds in the subdistrict.
5. The net bed need allocation for a subdistrict at the planning horizon is determined by subtracting the total number of licensed and approved beds for facilities licensed under Chapter 400, F.S., in the subdistrict from the bed allocation determined under subparagraphs (c)1. through (c)4. unless OR, as defined in subparagraph (c)4. is less than 85 percent, in which case the net bed need allocation is zero. The number of licensed beds that is subtracted from the bed need allocation shall be the

METHODOLOGY

Committee staff reviewed national trends in nursing home placement and occupancy rates for nursing homes in Florida during the moratorium. Staff reviewed other types of assistance to the elderly that the state has provided during the years the moratorium has been in effect; consulted with representatives of the state's three nursing home industry associations concerning the effects of the moratorium on the providers they represent; and consulted with AHCA staff concerning nursing home quality indicators, occupancy rates, service for Medicaid recipients, and nursing home bed-need projections.

FINDINGS

The Need for New Nursing Home Beds

The statewide occupancy rate for nursing homes was 88.63 percent for the first half of 2004 and it was 87.62 percent for the second half of that year[5]. For the planning horizon January 2008, four areas of the state have a nursing home occupancy rate above 94 percent, as follows:

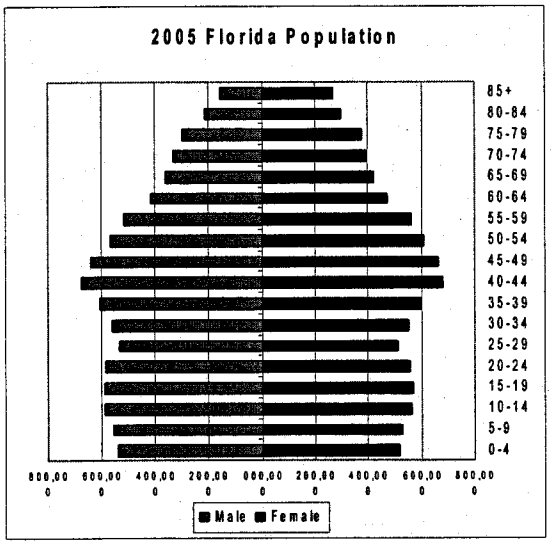
Leon County	96.97%
Columbia/Hamilton/Suwannee Counties	96.78%
Nassau/N. Duval Counties	94.70%
Seminole County	94.44%

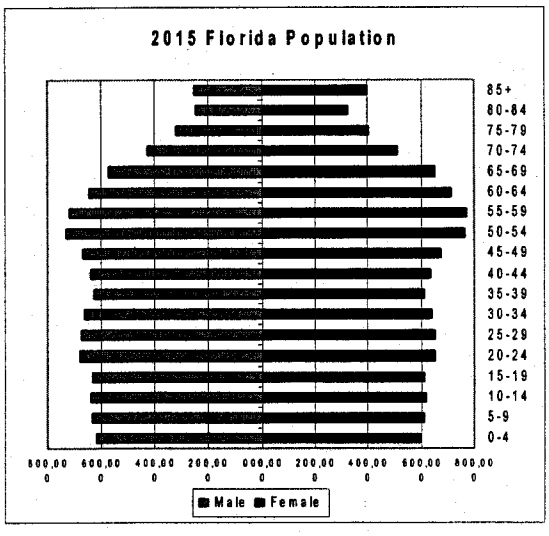
The number of beds required to address the need in these four areas will be:

Leon County	68 beds
Columbia/Hamilton/Suwannee Counties	70 beds
Nassau/N. Duval Counties	30 beds
Seminole County	111 beds

In the next 10 years, Florida's total population will increase by 19.1 percent (from 17.8 million in 2005, to 21.2 million in 2015). The population age 65 and older will increase at a faster rate than the population as a whole. The population age 65 or older will increase by 32.2 percent (from 3.1 million in 2005 to 4.1 million in 2015). The population age 75 and older, which receives heavier weighting in the nursing home bed-need methodology, will increase by 21.1 percent (from 1.6 million in 2005 to 1.9 million in 2015). And the oldest segment of the population—those 80 years old or older—will increase by 53.3 percent (from 422,166 in 2005 to 647,044 in 2015).

The charts below[6] show the age and gender distribution of Florida's total population in 2005 and 2015.





number licensed under Chapter 400, F.S., as of the most recent published deadline for agency initial decisions prior to publication of the fixed bed need pool. The number of approved beds that is subtracted shall be the number for which the agency has issued a certificate of need, a letter stating the agency's intent to issue a certificate of need, a signed stipulated agreement, or a final order granting a certificate of need, as of the most recent published deadline for agency initial decisions prior to publication of the fixed bed need pool. (Rule 59C-1.036, F.A.C.)

[5] Florida Agency for Health Care Administration. 2005.

[6] Source: Florida Legislature. Office of Economic and Demographic Research. Demographic Estimating Conference Database, updated July 2005.

Within the next 10 years, Florida will need more nursing home beds. Predicting how many, when, where, and what type is difficult because the factors that affect the health and independence of Florida's elderly population will be changing during that decade. A 2002 report by AHCA predicted that, based on bed ratios per 1,000 individuals aged 65 and older and assuming a 95 percent occupancy rate, Florida would need 33,046 more nursing home beds by 2015.[7] At 95 percent of the 2002 bed ratio, the report projected that Florida would need 27,305 more nursing home beds in 2015, and at 75 percent of the 2002 bed ratio, Florida would need 4,300 beds by that date. The use of bed-to-population ratios in the AHCA report could be considered a conservative method because Florida's nursing home bed supply had been limited by CON regulation throughout the decade preceding the study. However, national predictions of the number of older Americans who would be in nursing homes by a certain date assumed that utilization rates would be the same in the future as they were at the time of the prediction, and that did not turn out to be the case. "The number of older persons in nursing homes in 1999 was more than half a million below the number that would have been expected if 1973-74 utilization rates had continued."[8] Nationally, utilization of nursing home beds by persons aged 65 and older has declined for the total population but has increased for Black or African American residents.[9]

The factors that could have contributed to lower national utilization rates in nursing homes include declining disability among the elderly and changes in policies for the provision of long term-care that emphasize helping the individual to stay autonomous in his or her own home. The disability that accompanies old age has been declining for the past several decades.[10] That is, the current population age 65 and older is less disabled than comparable age cohorts in previous generations. They are able to function and live independently to a greater extent and to a later age than was the case for members of previous generations. The factors that could contribute to the decline of disability include:

- Medical care improvements such as pharmaceutical drugs to address chronic diseases and procedures such as joint replacement to permit mobility;
- Changes in health behavior such as a decline in smoking and trends toward low-fat and reduced-salt foods;
- Increased use of aids such as walkers, handrails, and bathrooms and kitchens that are accessible by persons with disabilities
- Higher socioeconomic status accompanied by increased levels of education and jobs that pose fewer health hazards
- Disease exposure throughout the lifespan, which declined in the 20th century because of discoveries for prevention and treatment; and
- Social support that improves social engagement and cognitive functioning and reduces stress.[11]

Alternative types of long-term care probably have contributed to a reduction in nursing home admissions by providing support for elderly individuals. These alternatives include:

- Assisted living facilities (ALFs)
- Home health care
- Home and community-based services

Florida's "oldest old" population, those age 85 and older, is projected to be 647,044 in 2015. "The size of the oldest-old population is a somewhat better indicator of the level of need for long-term care than the elderly population in general, since frailty increases with age."[12] A need for new nursing home beds may well occur coincidentally with the aging of the oldest old.

Nursing home access for Medicaid recipients is required in the criteria used to evaluate CON applications. At present, nursing homes throughout Florida serve Medicaid recipients and none reports a lack of capacity to do so. A likely first signal that the bed supply is becoming inadequate will be when providers cannot find a nursing home placement for Medicaid recipients.

The state's total Medicaid nursing home bed days for each of the past five years are shown in the chart below:

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[7] Florida Agency for Health Care Administration. *Proposal to Reduce Medicaid-Funded Nursing Home Bed Days in Florida*. 2002. p. 26.

[8] Redfoot, D. and Pandya, S. *Before the Boom; Trends in Long-Term Supportive Services for Older Americans with Disabilities*. AARP. 2002. p. 5

[9] National Center for Health Statistics. *Chartbook on Trends in the Health of Americans*. 2004, p. 305

[10] Cutler, D. "Declining Disability among the Elderly". *Health Affairs*. Vol. 20, No. 6, 2001

[11] *Ibid.*

[12] Florida Agency for Health Care Administration. *Proposal to Reduce Medicaid-Funded Nursing Home Bed Days in Florida*. 2002. p.15.

Year	Medicaid Bed Days
2000	16,429,814
2001	16,281,639
2002	16,270,629
2003	16,476,569
2004	16,356,782

Representatives of the state's three nursing home associations—the Florida Health Care Association, the Florida Association of Homes for the Aging, and the Florida Long-Term Health Care Association—reported that their industry does not see a need to lift the moratorium at this time. They agreed that an exception to the moratorium should be provided for nursing homes where the occupancy rate exceeds 96 percent and the home has a record of providing high-quality care. They recommended that in such circumstances, a minimum occupancy level for the subdistrict should be a criterion for the exception.

While there is not currently a need for nursing home beds in Florida, and the projected need is for 279 beds in 2008, there will be a need for many more beds as the elderly population increases. In 2003, Florida ranked 48th in the nation in the number of beds per 1,000 population age 65 and older.[13] If Florida is to continue a policy of closely coordinating the number of beds to the need for beds, the state must plan within the next 5 years for the increase in the elderly population.

Planning for new nursing homes must take into account Florida's ethnic make-up and the differences in utilization of nursing homes and other health care services by White non-Hispanic, Black non-Hispanic, and Hispanic elderly. The ethnic make-up of Florida's population age 75 and over will change over the next 10 years. White non-Hispanic residents age 75 and older who comprise 7.6 percent of the population in 2005 will decline to 7.3 percent of the population in 2015 (from 1,351,621 in 2005, to 1,563,507 million in 2015, representing an increase in number but a decline in proportion relative to other groups). Black non-Hispanic residents age 75 and older will increase from .5 percent of the population in 2005 to .6 percent in 2015 (from 83, 046 in 2005, to 124,893 in 2015). Hispanic residents who comprise .9 percent of the population in 2005 will increase to 1.1 percent of the population in 2015 (from 155,790 in 2005, to 232,020 in 2015).

[13] Gibson, M. Gregory, S. Houser, A. and Fox-Grange, W. *Across the States: Profiles of Long-Term Care 2004.* AARP. 2004.

Statutory Placement of the Moratorium

The moratorium on approval of certificates of need for additional nursing home beds was enacted in s. 52 of ch. 2001-45, L.O.F.; this section was omitted from the statutes because it was a temporary provision that will expire in 2006. However, after s. 52 of ch. 2001-45, L.O.F., was amended by the 2004 Legislature, the Division of Statutory Revision codified s. 52 and the subsequent amendments to it at s. 651.1185, F.S., in a chapter that governs continuing care contracts. With the publication of the 2004 Florida Statutes, it became appropriate to cite s. 651.1185, F.S., as the law that imposes a moratorium on approval of certificates of need for additional nursing home beds.

In reviewing the moratorium, staff found that the placement of the moratorium in ch. 651, F.S., amid statutes for continuing care contracts, rather than in ch. 408, F.S., which governs health care administration, including certificate-of-need review, is confusing. In fact, a number of experts on the subject did not know that the moratorium had been codified in ch. 651, F.S. If the moratorium is continued, s. 651.1185, F.S., should be moved to ch. 408, F.S.

RECOMMENDATION

Section 651.1185, F.S., should be moved to ch. 408, F.S., and amended to extend the moratorium on the approval of certificates of need for additional nursing home beds until July 1, 2011. In order to ensure access, an exception to the moratorium should be permitted to allow nursing homes with a 96 percent or greater occupancy rate to add 10 beds or 10 percent of the number of licensed beds if the home had no class I or class II deficiencies in the past 30 months and the occupancy rate in the planning subdistrict is 94 percent or greater. This exception is the same policy as the exemption to CON review under s. 408.036(3)(j), F.S., which is not currently available to nursing homes because of the moratorium. If the Legislature enacts this recommendation, the moratorium would stay in effect for five more years, and AHCA would have the authority to grant an exception to the moratorium for nursing homes that provide a good quality of care and that are operating at what is essentially full capacity.